

Child's Name:

Child's DOB:

Screeners Name:

Screen Date:

Children's Personal Care Services—Functional Ability Screening Tool

Age Cohort: 36 Months-4 Years

Activities of Daily Living Section:

Choose only ONE response—the most representative need in each area. Choosing multiple responses may delay the final determination and/or result in the Functional Ability Screening Tool returned. Please provide additional detail/comments to describe strengths and need.

If you select "None of the Above Apply", you must include comments related to child's functioning in the "Notes" section. Be sure to indicate if the functional impairment is expected to last for at least one year, in each domain.

BATHING: The ability to shower or bathe—does not include hair care. Does include the ability to get in or out of the tub, turn faucets on &/or off, regulate temperature & fully wash & dry. (☒ Mark only one choice)

- ☐ Needs adaptive equipment
- ☐ Becomes agitated requiring alternative bathing methods
- ☐ None of the above apply

Is the bathing functional impairment expected to last for at least one year from the date of screening?

- ☐ Y
- ☐ N

Notes:

GROOMING: Brushing teeth, washing hands & face. Due to variation in hair care by culture, length of hair, etc., hair care is NOT considered. (☒ Mark only one choice)

- ☐ Is combative during grooming (e.g., flails, clamps mouth shut, takes 2 caregivers to accomplish task)
- ☐ None of the above apply

Is the grooming (brushing teeth, washing hands and face) functional impairment expected to last for at least one year from the date of the screening?

- ☐ Y
- ☐ N

Notes:

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DRESSING: The ability to dress as necessary; does not include the fine motor coordination for fasteners. (☒ Mark only one choice)

- ☐ Does not assist with dressing by helping to place arms in sleeves or legs into pants
- ☐ Unable to undress self independently
- ☐ None of the above apply

Is the dressing functional impairment expected to last for at least one year from the date of the screening?

- ☐ Y
- ☐ N

Notes:

EATING: The ability to eat & drink by finger feeding or using routine &/or adaptive utensils; includes ability to swallow sufficiently to obtain adequate intake. Does NOT include cooking food or meal set-up. (☒ Mark only one choice)

- ☐ Receives tube feedings or TPN
- ☐ Requires more than three hours per day of feeding or eating
- ☐ Needs to be fed
- ☐ Needs one-on-one monitoring to prevent choking, aspiration, or other serious complication
- ☐ None of the above apply

Is the eating functional impairment expected to last for at least one year from the date of the screening?

- ☐ Y
- ☐ N

Notes:

Child's Name:

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Screen Date:

TOILETING: The ability to use a toilet or urinal, transferring on/off a toilet & pulling down/up pants. Does not include behavioral challenges involving voiding &/or defecating. (☒ Mark only one choice)

- ☐ Has no awareness of being wet or soiled
- ☐ Does not use toilet/potty chair when place there by a caregiver
- ☐ None of the above apply

Is the toileting functional impairment(s) expected to last for at least one year from the date of the screening?

- ☐ Y
- ☐ N

Notes:

MOBILITY: The ability to move between locations within environments, including home, school & the community. This includes walking, crawling & wheeling oneself. (☒ Mark only one choice)

- ☐ Does not walk or needs physical help to walk
⇒ If, this is the most appropriate response, please complete the Supplemental Screening Questionnaire related to Mobility on page 5
- ☐ Uses wheelchair or other mobility device as primary method of mobility not including a single cane
⇒ If, this is the most appropriate response, please complete the Supplemental Screening Questionnaire related to Mobility on page 5
- ☐ None of the above apply

Is the mobility functional impairment checked expected to last for at least one year from the date of the screening?

- ☐ Y
- ☐ N

Notes:

Child's Name:

Child's DOB:

Screen Date:

TRANSFERS: The physical ability to move between surfaces: e.g., from bed/chair to wheelchair, walker or standing position. Does NOT include transfer into bathtub or shower, on/off toilet, or in/out of vehicle. Does NOT refer to a child's challenges related to *transitions*. (☒ Mark only one choice)

☐ Needs physical help with transfers

⇒ If, this is the most appropriate response, please complete the Supplemental Screening Questionnaire related to Transfers on page 6:

☐ Uses a mechanical lift

☐ None of the above apply

Is the transfers (does not include bathtub or shower) functional impairment expected to last for at least one year from the date of this screening?

☐ Y

☐ N

Notes:

⇒ If directed by specific responses within a domain, go to pages 5-6 to complete all applicable sections of Supplemental Screening Questionnaire.

If Supplemental Screening Questionnaire is not applicable, skip to page 7 to return to Functional Ability Screening Tool to complete Instrumental Activities of Daily Living portion.

Children's Personal Care Services—Supplemental Screening Questionnaire

Age Cohort: 36 Months-4 years

To be completed to provide additional information related to previous responses in ADL section of the Functional Ability Screening Tool. Respond **only** to these additional questions if prompted to within the Functional Ability Screen.

MOBILITY: The ability to move between locations within environments, including home, school & the community. This includes walking, crawling & wheeling oneself.

If, "uses wheelchair or other mobility device as primary method of mobility (not including a single cane)" was selected, does the child:

- ☐ Self-propel manual wheelchair for primary mobility
- ☐ Drive power wheelchair for primary mobility
- ☐ Require extensive assistance to operate the wheelchair and/or device

If "does not walk or needs physical help to work" was selected, does the child:
Walk with assistance for primary mobility?

- ☐ Y
- ☐ N

If yes, what method and level of support does the child require:

Method:

- ☐ Hand held
- ☐ Cane
- ☐ Walker
- ☐ Crutches
- ☐ Orthotics
- ☐ Other (must specify):

Level of Support:

- ☐ Supervision
- ☐ Minimal Assist
- ☐ Moderate Assist

If the child does not walk with assistance, please specific child's individual needs/challenges below.

Notes:

Child's Name:

Child's DOB:

Screen Date:

TRANSFERS: The physical ability to move between surfaces: e.g., from bed/chair to wheelchair, walker or standing position. Does NOT include transfer into bathtub or shower, on/off toilet, or in/out of vehicle. Does NOT refer to a child's challenges related to *transitions*.

If "requires physical assistance to transfer; child is able to bear weight and pivot" was selected to best describes the child's need:

Can the method and level of support described as (please choose only one in each category)?

- ☐ Y
☐ N

If yes, what method and level of support does the child require:

Method:

- ☐ Stand pivot
☐ Lateral
☐ Sliding board
☐ Other (**must specify**):

Level of Support:

- ☐ Supervision
☐ Minimal Assist
☐ Moderate Assist

If "requires complete physical assistance to transfer" was selected, is the assistance the child receives:

- ☐ One-person
☐ Two-person
☐ Mechanical lift
☐ Other (**must specify**):

Notes:

⇒ Return to Functional Ability Screening Tool to complete Instrumental Activities of Daily Living Section

Child's Name:

Child's DOB:

Screen Date:

Children's Personal Care Services—Functional Ability Screening Tool

Age Cohort: 36 Months-4 years

Instrumental Activities of Daily Living Section:

Categories included below provide information included in determining appropriateness of Children's Personal Care Services, as well as for screening and referral determination for other Integrated Family Services supports.

Choose as many options as apply. Please provide additional detail/comments to describe strengths and needs. If you select "None of the Above Apply", you must include comments related to child's functioning in the "Notes" section. Be sure to indicate if the functional impairment is expected to last for at least one year, in each domain.

COMMUNICATION:

- ☐ A norm-referenced assessment in receptive language within the last six (6) months. (A substantial impairment is defined by results that indicated a delay in 30% or greater or 2 Standard Deviations (SD) below the mean)

Assessment Date: ____ / ____ / ____ (mm/dd/yyyy)

Assessment Tool:

See list of "Norm-Referenced Assessment Tools for **Communication** and **Growth and Development**"

Within normal limits

Less than 30% delay

Greater than or equal to 30% delay

Less than 2 Standard Deviations (SD) below the norm

Greater than or equal to 2 Standard Deviations (SD) below the norm

- ☐ A norm-referenced assessment in expressive language within the last six (6) months. (A substantial impairment is defined by results that indicated a delay in 30% or greater or 2 Standard Deviations (SD) below the mean)

Assessment Date: ____ / ____ / ____ (mm/dd/yyyy)

Assessment Tool:

See list of "Norm-Referenced Assessment Tools for **Communication** and **Growth and Development**"

Within normal limits

Less than 30% delay

Greater than or equal to 30% delay

Less than 2 Standard Deviations (SD) below the norm

Greater than or equal to 2 Standard Deviations (SD) below the norm

Child's Name:

Child's DOB:

Screen Date:

COMMUNICATION (cont'd):

- ☐ Does not follow two-step instructions that are related and are not routine
- ☐ Does not understand any preposition in unfamiliar single step instructions
- ☐ Does not use at least 50 words
- ☐ Does not use "mine" to indicate possession
- ☐ None of the above apply

Is this communication functional impairment expected to last for at least one year from the date of the screening?

- ☐ Y
- ☐ N

Notes:

LEARNING:

- ☐ Has a valid full-scale IQ (a substantial functional impairment is defined by a full-scale IQ of 75 or less)

IQ Test: _____

Score: _____

- ☐ A norm-referenced assessment in expressive language within the last six (6) months. (A substantial impairment is defined by results that indicated a delay in 30% or greater or 2 Standard Deviations (SD) below the mean)

Assessment Date: ____ / ____ / ____ (mm/dd/yyyy)

Assessment Tool: _____

See list of "Norm-Referenced Assessment Tools for **Communication** and **Growth and Development**"

Within normal limits

Less than 30% delay

Greater than or equal to 30% delay

Less than 2 Standard Deviations (SD) below the norm

Greater than or equal to 2 Standard Deviations (SD) below the norm

Child's Name:

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Screen Date:

LEARNING (cont'd):

- ☐ Cannot match 3 shapes or 3 colors
- ☐ Cannot rote count to 10 without mistakes
- ☐ Cannot count 3 objects
- ☐ Cannot maintain an attention span of at least three minutes for an enjoyable activity (not including self-stimulating behavior)
- ☐ None of the above apply

Is the learning functional impairment expected to last for at least one year from the date of the screening?

- ☐ Y
- ☐ N

Notes:

SOCIAL COMPETENCY:

- ☐ **Does not parallel play with other children**
Is not comfortable playing with similar toys next to other children.
- ☐ **Does not assume different roles in play**
Does not engage in make-believe or pretend play (e.g., pretends to play a mom, dad, cat or dog)
- ☐ **Does not play in groups with adult supervision**
Will not play games lead by trusted adults such as Hokey-Pokey, circle games or Simon Says
- ☐ None of the above apply

Is the social competency functional impairment expected to last for at least one year from the date of the screening?

- ☐ Y
- ☐ N

Notes: